Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW000	INITIAL COMMENTS This Regulation is not met as evidenced by: The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of a State Licensure conducted at your facility on 7/16/09. The survey was conducted using Nevada Administrative Code (NAC) 449, Halfway Houses for Recovering Alcohol and Drug Abusers Regulations, adopted by the Nevada State Board of Health on December 17, 2001 with an effective date of 01/01/02. The facility is licensed for forty-two beds. The census at the time of the survey was thirty-two The following deficiencies were identified:	WW000		
WW009 SS=C	ADMINISTRATOR GENERAL DUTIES NAC 449.1254911: An administrator shall: (3) Establish policies, procedures and rules for the operation of the facility, including, without limitation, the policies and procedures required to be established by NAC 449.154915.	WW009		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW009	Continued From page 1 This Regulation is not met as evidenced by: Based on interview on 7/16/09, the administrator failed to establish policies and procedures for the operation of the facility. Findings include: On 7/16/09, the policy and procedure manual was requested for review. The administrator reported the facility did not have a manual to review. Severity: 1 Scope: 3	WW009		
WW011 SS=F	ADMINISTRATOR GENERAL DUTIES NAC 449.154911: An administrator shall: (5) Ensure that the facility complies with any applicable state statutes and regulations and local ordinances. This Regulation is not met as evidenced by: NRS 652.060 " Medical laboratory " defined. " Medical laboratory " means any facility for microbiological, serological, immunohematological (blood banking), cytological, histological, chemical, hematological, biophysical, toxicological, or other methods of examination of tissues, secretions or excretions of the human body. The term does not include a forensic laboratory operated by a law enforcement agency. NRS 652.080 License required; term; renewal; inactive status; licensure of laboratory located outside state. 1. Except as otherwise provided in NRS 652.217	WW011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW011	Continued From page 2 and NRS 652.235, no person may operate, conduct, issue a report from or maintain a medical laboratory without first obtaining a license to do so issued by the Health Division pursuant to the provisions of this chapter. 2. A license issued pursuant to the provisions of subsection 1 is valid for 24 months and is renewable biennially on or before the date of its expiration. 3. No license may be issued to a laboratory which does not have a laboratory director. 4. A license may be placed in an inactive status upon the approval of the Health Division and the payment of current fees. 5. The Health Division may require a laboratory that is located outside of this state to be licensed in accordance with the provisions of this chapter before the laboratory may examine any specimens collected within this state if the Health Division determines that the licensure is necessary to protect the public health, safety and welfare of the residents of this state. Based on interview on 7/16/09, the facility did not have a State license to conduct screening tests on 36 of 36 residents. Findings include: On 7/16/09, it was discovered during the survey staff were testing the urine of residents if staff believed them to be under the influence of controlled substances. Severity: 2 Scope: 3	WW011		
WW014 SS=C	ADMINISTRATOR GENERAL DUTIES NAC 449.154911: An administrator shall: (8) Review and approve changes in the policies and procedures established pursuant to	WW014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW014	Continued From page 3 subsection 3 at least annually. This review must be signed and dated. This Regulation is not met as evidenced by: Based on interview on 7/16/09, the administrator failed to annually review policies and procedures for the operation of the facility. Findings include: On 7/16/09, the policy and procedure manual was requested for review. The administrator reported the facility did not have a policy and procedure manual for review or annually review the documents. Severity: 1 Scope: 3	WW014		
WW027 SS=C	POLICIES AND PROCEDURES; ESTABLISHMENT; MAINT NAC 449.154915: (2) The administrator shall maintain a manual of policies, procedures and rules of the facility that includes the policies and procedures established pursuant to subsection 1. The manual must be available on the premises of the facility at all times. This Regulation is not met as evidenced by: Based on interview on 7/16/09, the administrator failed to maintain a manual of policies and procedures on the premises of the facility at all	WW027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW027	Continued From page 4 times. Findings include: According to NAC 449.154915, the facility must have policy and procedures concerning the following items: (a) The manner in which records of clients will be maintained and protected against unauthorized use; (b) The disclosure of confidential information about clients; (c) The criteria the facility will use to determine whether to: (1) Admit a client to the facility; and (2) Discharge a client from the facility; (d) The discharge of a client for a violation of the rules of the facility; (e) The discharge of a client for the use of alcohol or drugs; (f) The rights and responsibilities of a client; and (g) The evacuation of clients in case of fire or other emergency as required by NAC 449.154945. On 7/16/09, the policy and procedure manual was requested for review. The administrator reported he did not keep a manual of the policy and procedures covering the above listed items in the facility. Severity: 1 Scope: 3	WW027		
WW037 SS=F	HEALTH AND SANITATION NAC 449.154919: (5) All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be	WW037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW037	Continued From page 5 screened to prevent the entry of insects. This Regulation is not met as evidenced by: Based on observations on 7/16/09, all windows capable of being opened were screened to prevent the entry of insects. Findings include: During a facility tour on 7/16/09, the windows in bedrooms were missing screens. Severity: 2 Scope: 3	WW037		
WW045 SS=C	BEDROOMS; BEDDING NAC 449.154925: (1) A bedroom in a facility that is used by more than one client must have at least 45 square feet of floor space for each client who resides in the bedroom. A bedroom that is occupied by only one client must have at least 80 square feet of floor space. This Regulation is not met as evidenced by: Based upon observation on 7/16/09, the facility failed to ensure each client had at least 45 square feet of floor space in their bedroom when shared by other clients. Findings include: The facility was licensed for forty-three beds and the current census was thirty-two. During the survey, 7 bedrooms were measured to determine bedroom space requirements. In addition, the number of beds were counted in each bedroom.	WW045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW045	Continued From page 6 Bedroom # 1 measured 138 square feet which allowed for three residents to share the bedroom, but the bedroom had four beds and the room was occupied by three residents. Bedroom #2 measured 180 square feet which allowed for four residents to share the bedroom. The bedroom met the space requirement with the four beds and was occupied by two residents. Bedroom # 3 measured 217 square feet which allowed for four residents to share the bedroom, but the bedroom had eight beds and the room was occupied by seven residents. Bedroom # 4 measured 325 square feet which allowed for seven residents to share the bedroom, but the bedroom had ten beds and the room was occupied by nine residents. Bedroom # 5 measured 264 square feet which allowed for five residents to share the bedroom, but the bedroom had eight beds and the room was occupied by eight residents. Bedroom #6 measured 400 square feet which allowed for eight residents to share the bedroom. The bedroom met the space requirement with the seven beds and was occupied by five residents. The " cooks " bedroom (managers) measured 165 square feet which allowed for three residents. The bedroom met the space requirement with the two beds occupied by the manager and assistant manager. Based on the 45 square footage per resident requirement if sharing a bedroom, the facility must remove the extra beds and only be licensed for thirty-two beds. The manager and assistant manager ' s beds are not included in the licensed total. Severity: 1 Scope: 3	WW045		
WW062 SS=F	MEDICATION	WW062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW062	Continued From page 7 NAC 449.154935: (2) Medication for self-administration may be kept at the facility. That medication must: (b) Be stored and controlled in a manner that protects the medication from unauthorized use. This Regulation is not met as evidenced by: Based upon observation and interview on 7/16/09, the facility failed to ensure resident medications were maintained in a secure environment. Findings include: On 7/16/09, it was observed the medication cabinet was unsecured and failed to have a locking mechanism. The administrator acknowledged the absence of a lock on the medication cabinet. Severity: 2 Scope: 3	WW062		
WW076 SS=C	CLIENT FILES; MAINTENANCE; CONTENTS; CONFIDEN NAC 449.154943: (1) An administrator shall ensure that the facility maintains a separate file for each client of the facility and retains the file for at least 5 years after the client permanently leaves the facility. The file must be kept locked in a location that is protected against unauthorized use. Each file	WW076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW076	Continued From page 8 must contain the information obtained by the facility that is related to the client, including, without limitation: (a) The full name, address, date of birth and social security number of the client. This Regulation is not met as evidenced by: Based upon observation on 7/16/09, the facility failed to ensure resident files were maintained in a secure environment. Findings include: On 7/16/09 resident files were observed unsecured in a card filing case on the administrator's desk. Severity: 1 Scope: 3	WW076		
WW079 SS=F	CLIENT FILES; MAINTENANCE; CONTENTS; CONFIDEN NAC 449.154943: (1) An administrator shall ensure that the facility maintains a separate file for each client of the facility and retains the file for at least 5 years after the client permanently leaves the facility. The file must be kept locked in a location that is protected against unauthorized use. Each file must contain the information obtained by the facility that is related to the client, including, without limitation:	WW079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW079	Continued From page 9 (d) Evidence of compliance with the provisions of NAC 441A.380. This Regulation is not met as evidenced by: Based on record review on 7/16/09, the facility failed to ensure 10 of 10 residents complied with NAC 449.380 regarding tuberculosis (TB) testing . Findings include: Resident #1- The resident's file did not contain evidence of a positive TB skin test, and therefore requiring the documented chest X-Ray. The file did not contain a completed annual TB symptom form. Residents #2 - 10 The resident's files failed to contain evidence of a two-step TB skin tests. Severity: 2 Scope: 3	WW079		
WW086 SS=F	SAFETY FROM FIRE NAC 449.154945: (2) The administrator shall ensure that the facility has a plan for the evacuation of clients in case of fire or other emergency. The plan must be: (c) Discussed with each client at the time of his admission.	WW086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW086	Continued From page 10 This Regulation is not met as evidenced by: Based on record review on 7/16/09, the administrator failed to ensure the evacuation plan had been shared with 10 of 10 residents. Findings include: Ten resident files were reviewed. The files did not contain evidence the evacuation plan had been discussed with residents at admission. Severity: 2 Scope: 3	WW086		
WW090 SS=C	SAFETY FROM FIRE NAC 449.154945: (b) Posted in common area of the facility This Regulation is not met as evidenced by: Based on observation and interview on 7/16/09, the facility failed to ensure the smoking policy was posted. Findings include: On 7/16/09, the smoking policy was not posted in any area of the facility. The administrator said the no smoking sign was removed during painting/renovations. Severity: 1 Scope: 3	WW090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW093	Continued From page 11	WW093		
WW093 SS=F	NAC 449.441A.375 Management of cases and suspected cases NAC 441A.375: Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a	WW093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW093	Continued From page 12 history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge	WW093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3455HWH	A. BUILDING _____ B. WING _____	07/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN HOUSE INC	1001 NORTH 4TH STREET LAS VEGAS, NV 89101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
WW093	Continued From page 13 of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. This Regulation is not met as evidenced by: Based on record review on 7/16/09, the facility failed to ensure employees had a pre-employment physical examination. Findings include: On 7/16/09, file review of 4 of 4 employees failed to provide evidence of an employment physical. Severity: 2 Scope: 3	WW093		